Meeting Record

Governor's Task Force on Drug Enforcement, Treatment, and Prevention

January 29, 2016 | 9:00 a.m. – 1:00 p.m. | Ivy Tech Event Center | Indianapolis

Facilitators:
John Hill, Office of the Governor
Dr. John Wernert, Indiana Family Social Services Administration

Task Force Members Present:
Superintendent Doug Carter, Indiana State Police
Judge Roger Duvall, Scott County Circuit Court
Dr. Joan Duwve, Indiana State Department of Health
Representative Wendy McNamara, Indiana House of Representatives
Dr. Jerome Adams, Indiana State Department of Health
Dr. Charles Miramonti, Indiana University Medicine/Indianapolis EMS
Senator Jim Merritt, Indiana State Senate
Judge Wendy Davis, Allen County Superior Court
Dr. Joseph Fox, Anthem, Inc.
Jane Bisbee, Indiana Department of Child Services
Dan Miller, Indiana Prosecuting Attorneys Council
Sheriff John Layton, Marion County Sheriff's Department

Others Present:

Presenters:
Luke Bosso, Indiana Department of Child Services
Josh Martin, Indiana Office of Management and Budget
Dr. Dan O'Donnell, Medical Director for Indianapolis EMS
Warren Forgey, President and CEO of Schneck Medical Center
Ann Vermilion, Administrative Director of Medical Staff Services and Community Outreach at Marion General Hospital
Jim Fuller, President of the Indianapolis Coalition for Patient Safely, Inc.
Dr. John Wernert, Indiana Family and Social Services Administration
Dr. Jerome Adams, Indiana State Department of Health

Staff Support to the Task Force
Veronica Schilb, Office of the Governor
Devon McDonald, Indiana Criminal Justice Institute
Diane Haver, Indiana Judicial Center

Public:

Megan Walradth	Lori Springer	Brandon Heget	Leonard Baker
Brandon Smith	Mike Brady	Josh Martin	Scott Phillips Dan
Becky Calhoun	Mike Rinebold	Debra Buckner	O'Donnell
Rob Pruat	David Clark	Trent Fox	Kristen Kelly
Steve McCaffry	Desmond Bunks	Kaitlyn Boice	Jim Friller
Brian Tabor	Monica Kozlowski	Kourtnaye Sturgem	
Wende Shipley	Jennifer Swartz	Aaron Kochar	
Kate Kerrigan	Randy Miller	Cindy Ziemke	

Task Force Members Absent:
Reverend Rabon Turner Sr., New Hope Missionary Baptist Church
Representative Terry Goodin, Indiana House of Representatives
Tony Gillespie, Indiana Minority Health Coalition
Dr. Tim Kelly, Community Health
Justice Mark Massa, Indiana Supreme Court
Sen. Jim Arnold, Indiana State Senate
Bernard Carter, Lake County Prosecutor
Michael Diekhoff, Bloomington Police Department
Bruce Lemmon, Indiana Department of Correction

Meeting Summary:

- Presentations were provided in the areas of a state-wide addiction hotline, drug use data in Indiana, the Naloxone Initiative, and issues faced by rural hospitals in the area of substance addictions.
- An update on MHPAEA and HIP 2.0 was provided by Dr. Wernert.
- A legislative update was provided by Senator Merritt.
- Open Task Force discussion continued at length.
- The Task Force agreed on a recommendation for the Governor to identify a county criminal justice entity and implement a therapeutic program for offenders while incarcerated and awaiting adjudication.

Presentations:

Indiana Addiction Hotline
Kevin Moore, Director Division of Mental Health and Addiction
Luke Bosso, Indiana Department of Child Services

Kevin Moore presented to the Task Force information on the Indiana Addictions Hotline that provides crisis interventions for substance addictions and gambling. The phone number is 1-800-662-4357. Master's level counselors are in place to answer crisis calls. The counselors follow a crisis protocol and refer to appropriate agencies and/or providers. Counselors also follow a protocol for repeat callers. Mr. Moore referenced the slides (attached) in order to illustrate the number of calls in 2015 and the details behind those calls. The data has shown an increase in calls from fiscal years 2014 to 2015. Thus, the increase in calls indicates an increase in the number of people in need of services. According to the charts, Marion, Lake, St. Joseph, and Allen counties have the highest volume of calls and the numbers continue to grow. They are currently looking at existing examples in order to increase the awareness and access to additional hotline services.

Luke Bosso presented to the Task Force on the expansion of the hotline, which would theoretically utilize one number for all substance abuse issues. In doing so, data tracking would be made possible in order to identify the population most impacted. Age, gender, location, type of drugs by county, etc., could be tracked. Mr. Bosso noted that if Indiana had its own statewide hotline, the hotline employees would be similarly trained. Furthermore, an expansion of the hotline would allow for various means of communication among those in need of services, such as texting and social media interactions, providing more accessibility to the user. In order to increase awareness, a stakeholder could launch a statewide campaign. It is projected that the hotline could begin operating in 60 to 100 days, if taken in phases. For example, phase one would include the state-wide phone hotline, phase two would add the texting capability, then phase three would add the social media component.

Mr. Bosso answered questions asked by the Task Force members.

PLA Public Service Announcement

Dr. Wernert presented the PLA public service announcement to the Task Force Members. He and Dr. Adams noted the critical importance of increasing the public's awareness of Naloxone. The public service announcement is one step in building the resources to increase awareness across the state. The announcement may be viewed at: https://www.youtube.com/watch?v=yTqFHUSaWaQ&feature=youtu.be

Legislative Update
Senator Jim Merritt

Senator Jim Merritt provided the Task Force with a summary of the legislative dialogue pertaining to Naloxone and/or the war on drugs. He noted that the conversations are generally robust, provided with shocking details, and concerns are being taken into strong consideration. Senator Merritt reported that they have six additional ideas in the legislature that will serve to fight the war on drugs.

Management Performance Hub, Data Initiative
David Matusoff
Josh Martin

David is with the Office of Management and Budget. The goal of the agency is to provide data to the state in order to assist them in making data-informed decisions. They work strictly with data and are not subject-experts. Therefore, the information gathered may assist the stakeholders in making decisions that could be otherwise influenced by emotion or sensitivity. They currently have a project in place that began in November, which has tracked drug trends across the state. Actionable items have resulted in response to the collected data. For example, the Indiana State Police Department was awarded a grant to be used for the deployment of Naloxone by first responding officers. Furthermore, drug treatment data information has resulted in the identification of areas in need of opiate clinics.

Josh Martin presented slides (attached) to the Task Force that illustrated various drug trends across the state. He explained that a bulk of the data inputted is derived from the laboratory information utilized by the State Police. Mr. Marin referenced slide 13. The slide indicates that, according to lab submissions by year, cannabis and stimulants are generally reported in highest volume, followed by opioids. The slide illustrates the rapid increase in opioid lab submissions over the years. As of 2015, opioids lab submissions were the third highest drug submitted by volume. Slide 14 illustrates submissions per-capita. Mr. Martin explained that the per-capital instances are illustrated by the circles on the slide. The slide indicates a dramatic increase in opiates, particularly in the eastern part of the state. Slide 15 illustrates a rapid decrease in opiates, but the timing correlates to the enhanced prescription regulations enacted during that time. Furthermore, the decrease of opiates aligned with the dramatic increase of heroin. Mr. Martin noted to the Task Force that pharmacies are required to report loss of substances due to any cause, such as robbery, employee theft, etc. Slide 18 illustrates pharmacy loss throughout the state. Slide 20 illustrates the deaths associated with drugs, which can indicate gaps in treatment providers by area.

Mr. Matusoff and Mr. Martin answered questions asked by the Task Force Members.

Indiana EMS and IMPD Naloxone Initiative
Dr. Dan O'Donnell, Medical Director for Indianapolis EMS

Dr. Dan O'Donnell presented to the Task Force the experience of IMPD with Naloxone. He noted that it began with the need for a fundamental approach to address opiate use in Indiana. They turned to other states and reached out to public health leaders while listening to their stories of failure and success. The factor of lost time had an impact on the Naloxone policy. For example, police would often arrive to the scene before the medical professionals. Thus, the idea of allowing police officers to administer Naloxone was considered. While the community was facing an epidemic, however, the solution must remain cost effective and uncomplicated. In response, a pilot was launched to train police officers on recognizing an overdose and on how to administer Naloxone is such cases. Dr. O'Donnell referenced his slides to note a few important points. Slide 33 illustrates the goal of the pilot was to train 150 officers on how to deliver a medication they may have only heard of. Potential barriers were identified, such as the responsibility extending beyond the scope of what a police officer was trained to do and officers may view the practice as enabling the individual in an overdose state. At the start of the pilot, they were met with criticism and negative attitude. They approached these notions with a quick training that was backed up by data to explain to the officers why they are the critical responder. During the training, the assumption that individuals suffering from an overdose would regain coherence in a combative state was countered as a myth. After the training was complete, they compiled surveys of those who completed the training. It was found that 85% of the trained officers did not think the Naloxone was difficult to administer. Slide 37 illustrates additional survey questions and responses. The pilot was successful and eventually implemented department-wide. Since launching the pilot and extending department-wide, there have been a total of 121 Naloxone administrations by an officer. The youngest recipient was 16 years of age and the oldest recipient was 82 years of age. The majority regained consciousness and only one individual became combative. About 95% survived and 90% were discharged from hospitals, which is an enormous cost-savings for the hospitals. Naloxone fills the time gap that is essential for survival, preventing deaths, brain damage, long-term care, etc. Dr. O'Donnell noted that rural communities are in great need of officer training since police generally respond well-ahead of EMS. The practice also utilizes a multi-disciplinary approach to combat overdose deaths. Upon an emergency department discharge, patients are linked with a social worker for discharge planning and continued care.

Indiana Hospital Association – Prescribing Guidelines and Patient & Community Engagement
Warren Forgey, President and CEO of Schneck Medical Center
Jim Fuller, President of Indianapolis Coalition for Patient Safely, Inc.
Ann Vermilion, Administrative Director of Medical Staff Services & Community Outreach, Marion General Hospital

Warren Forgey presented to the Task force on his concerns regarding the safety and security of his hospital staff members related to substance using patients. He reported that his clinical staff are afraid to come to work due to the violence on campus that occurs throughout the day. The staff members endure verbal and physical assaults from substance-using patients. Mr. Forgey has hired armed guards to protect his staff. He also reported that the hospital has seen a significant increase in emergency department visits from individuals seeking drugs and by those suffering from the ill-effects of coming off of a drug. They are also seeing babies being born addicted to drugs. They began to test mothers before delivery if suspicion of use is detected. Since then, 4% of newborns have been found addicted to drugs. They would like to expand on the number of drugs for which they test. He also noted that most patients of the like do not have the means to pay for the services they receive in his medical center.

Ann Vermilion presented to the Task Force on the patterns of over-prescribing of opiates in her community. She explained that after meeting with the Sheriff's Department, she was made shockingly aware that 80% of the pills confiscated from the streets were being prescribed by her doctors. She did not question the ethical practices of her doctors, but as a result of the Sheriff's report, she began to pull data. She found that 21% of those coming into the emergency department were leaving with an opiate prescription. In response, they implemented a prescribing guideline. She noted it was important for them

to communicate to their doctors that they believed in their medical practice. They had no intention of taking away their professional judgment. Additionally, they encouraged referrals. For example, for those patients coming in for a tooth ache, they would now refer to a dentist rather than providing a pain medication. They also began to refer to INSPECT.

Ms. Vermilion reported that they are advocates for INSPECT, but requested that the Task Force remain mindful of the limited resources among small hospitals as opposed to those available to the larger hospitals. She pointed out that the larger hospitals have abundant resources to access the INSPECT report in the most efficient manner. Senator Merritt noted that it is mandatory for physicians to sign up for INSPECT access, but it is not mandatory that they use the tool. Ms. Vermilion reported that they are moving towards requiring prescribing physicians to pull the INSPECT record prior to prescribing an opiate. Their practitioners believe in INSPECT. Before they launched the prescribing guideline practice, they worked with a narcotics team, law enforcement, all the local pharmacies, and five judges to gain support. Ms. Vermilion noted that they find great value in reaching out to the neighboring counties to explore the struggles in which the areas face. She also noted that Grant County is lacking in treatment facilities, but despite such a barrier, positive outcomes have been reported by those who complete the drug court program. Ms. Vermilion noted they did not have a model to which they could refer but would like one, particularly in the area of prescribing guidelines for acute and chronic pain. She also noted that the support of the area judges and prosecutors has been beneficial.

HIP 2.0 Update
Dr. Wenert, Indiana Family and Social Services Administration
Dr. Jerome Adams, Indiana State Department of Health

Dr. Wernert began by providing clarification on the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. Indiana has been a leader for 30 years in mental health parity. The mental health parity was passed in the early 1990s, but did not include substance treatment coverage. The 1996 act began treating mental health benefits the same as the benefits provided for medical or surgical conditions. The act continued with efforts to include substance abuse coverage and was passed in 2008. Historically, the insurer was not required to offer metal health or substance abuse coverage, but if coverage was offered, the insurer was required to provide coverage equal to that of physical coverage. After the ACA came aboard, they built on the 2008 act to fully cover mental health and substance abuse treatment plans. Dr. Wernert pointed to his presentation slides to illustrate the details of the act. Slide 110 notes that coverage for mental health and substance use disorder may be no more restrictive than coverage for medical or surgical conditions. Slide 111 illustrates that the MHPAEA law applies to both small and large employer insurance plans, individual market plans, CHIP, and Medicaid Alternative Benefit Plans and benchmark equivalent plans.

Dr. Wernert followed with an update on the rollout of HIP 2.0 and the data to date. He noted that HIP 2.0 coverage has been quite successful, particularly for those struggling with a substance use disorder. Slide 113 illustrates the numbers relative to HIP 2.0. More than 380,000 users are enrolled in HIP 2.0 and more than 150,000 enrollees have received mental health services. Approximately 23,583 enrollees have a substance use disorder, while 21,679 enrollees were reported as having received mental health services with substance abuse as a primary diagnosis.

Legislative Update
Senator Merritt
Senator Merritt provided the Task Force with the following legislative update:

- Senate Bill 187 allows for the purchase of Narcan without a prescription. The bill will be sent to the House.

- Senate Bill 271 will assign the Indiana Commission to Combat Drug Abuse to take the place of the Governor's Commission for a Drug Free Indiana. It allows for the coordination and communication across the system to gain efficiency and break down silos.
- The expansion of the Lifeline Law is controversial topic. The expansion allows for protection from legal consequence to individuals under the age of 21 in need of medical assistance in the event of a drug overdose.

Senator Merritt noted that the following bills were not endorsed by the Task Force, but relate to drug abuse:

- Senate Bill 186 – the bill will ensure that upon the release of toxicology results, pregnant women who test positive for the use of illicit drugs will receive encouragement to gain addictions treatment without having the records turned over to law enforcement.
- Senate Bill 205 – mirrors SB 1235 on controlled substances. Allows for specialized driving privileges under certain circumstances and provides detail on a possession conviction.
- Senate Bill 270 – Provides coverage for tamper-proof opiates. Purdue has new OxyContin that becomes ineffective if crushed.
- The Nosey Pharmacist bill to fight the meth problem.

The Task Force continued with deep discussion related to the above topics.

John Hill asked if the remaining Task Force group was in support of the recommendation to identify a county criminal justice entity and implement a therapeutic program for offenders while incarcerated and awaiting adjudication. All agreed. Representative McNamara recommended the participation of Steve McCaffrey.

The Task Force meeting adjourned at 1:03 pm.

Meeting Agenda

Governor's Task Force on Drug Enforcement, Treatment, and Prevention

January 29, 2016 | 9:00 a.m. – 1:00 p.m. | Ivy Tech Event Center | Indianapolis

9:00 a.m. – 9:05 a.m.	**Welcome** John Hill & Dr. John Wernert, Co-Chairs, Governor's Task Force on Drug Enforcement, Treatment, and Prevention
9:05 a.m. – 9:25 a.m.	**Indiana Addiction Hotline** Luke Bosso, Indiana Department of Child Services
9:25 a.m. – 9:30 a.m.	**PLA Public Service Announcement**
9:30 a.m. – 10:00 a.m.	**MPH Data Initiative** Josh Martin, Indiana Office of Management & Budget
10:00 a.m. – 10:45 a.m.	**Indianapolis EMS & IMPD Naloxone Initiative** Dr. Dan O'Donnell, Medical Director for Indianapolis EMS
11:00 a.m. – 12:00 p.m.	**Indiana Hospital Association - Prescribing Guidelines and Patient & Community Engagement** Warren Forgey, President and CEO of Schneck Medical Center Ann Vermilion, Administrative Director of Medical Staff Services & Community Outreach at Marion General Hospital Jim Fuller, President of the Indianapolis Coalition for Patient Safety, Inc.
12:00 p.m. – 12:15 p.m.	**HIP 2.0 Update** Dr. John Wernert, Indiana Family & Social Services Administration Dr. Jerome Adams, Indiana State Department of Health
12:15 p.m. – 12:20 p.m.	**Legislative Update**
12:20 p.m. – 1:00 p.m.	**Task Force Discussion on Recommendations**

* GOVERNOR'S *

TASK FORCE

on Drug Enforcement, Treatment & Prevention

Division of Mental Health and Addiction

Indiana Addictions Hotline
January 29, 2016

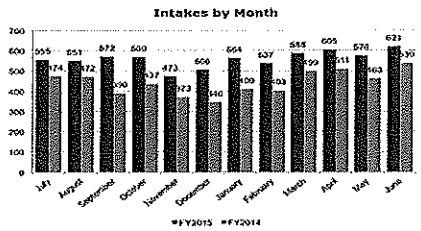
Indiana Addiction Hotline 1-800-662-4357

- Contractor: Bensinger, Dupont & Associates
- Hotlines for addiction, problem gambling, and consumer service line
- Master's Degreed Counselors answering calls 24/7
- Referrals to appropriate/DMHA-approved providers
- Crisis call protocol
- Repeat caller protocol

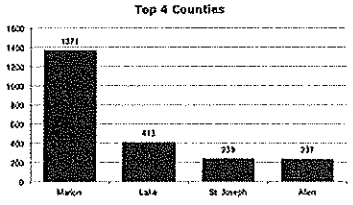
Indiana Addiction Hotline FY15 Report

- 6717 addiction calls
  - 4639 referrals made
  - 1369 transferred to provider
  - 391 Info only
- 26% increase in FY15
- 58% calls from self; 32% from family members
- 59% female; 41% male
- 11 crisis calls; 449 repeat callers
- Calls from all 92 counties

Indiana Addiction Hotline FY15 Report



Indiana Addiction Hotline FY15 Report



Expansion

- One number for all substance abuse issues
- Better identify the effected population
- Drill down on substance abuse issues
- Quality process and documentation of hotline information
- Provide analytical results to the drug task force

Updating Infrastructure

- Increase number of highly skilled clinical personnel answering the hotline
- Personnel would be dedicated to Indiana and would develop Indiana specific training for each hotline employee

Communications

- Add interactive texting and voice features
- Revamp existing website to make the hotline more accessible
- Develop ad campaign around single point of contact
- Social media monitoring

Timeline

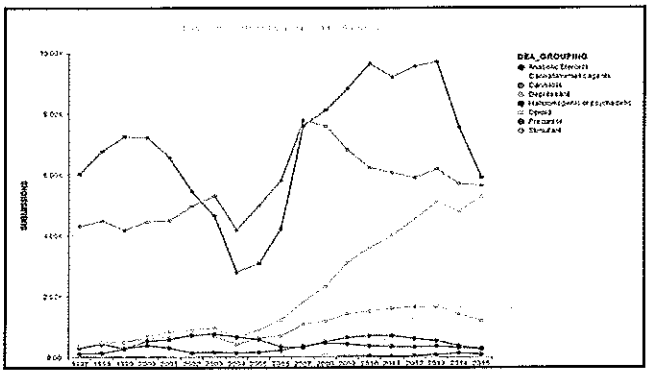
- An expanded hotline could be up and running as early as Q2 2016
- Implementation could be all at once or in multiple phases
- Hotline would be flexible to be able to add or decrease staff on monthly need

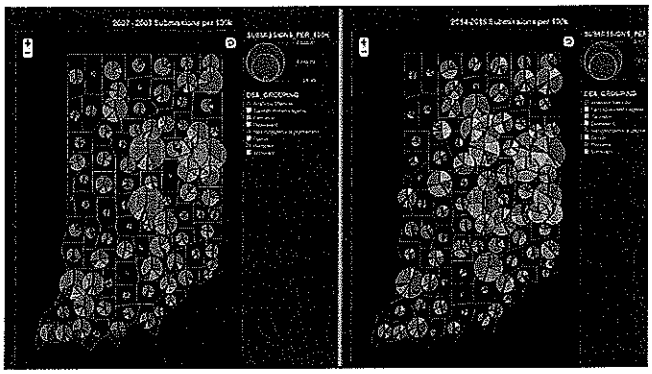
* GOVERNOR'S *

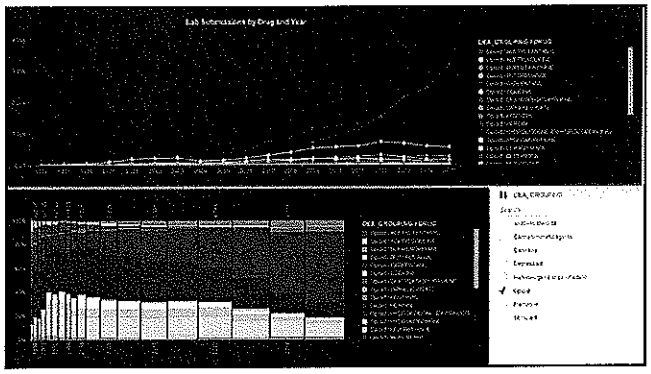
TASK FORCE

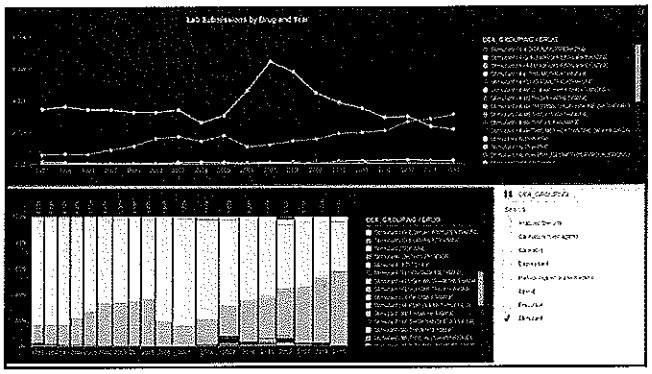
on Drug Enforcement, Treatment & Prevention

MPH Data Initiative


DEA_GROUPING
Analgesic Narcotics
Cannabis
Depressant
Hallucinogens or psychedelics
Opioid
Precursor
Stimulant
SUBMISSIONS


2007 - 2009 Submissions per 100k
2014-2015 Submissions per 100k
DEA_GROUPING


Lab Submissions by Drug and Year
DEA_GROUPING / DRUG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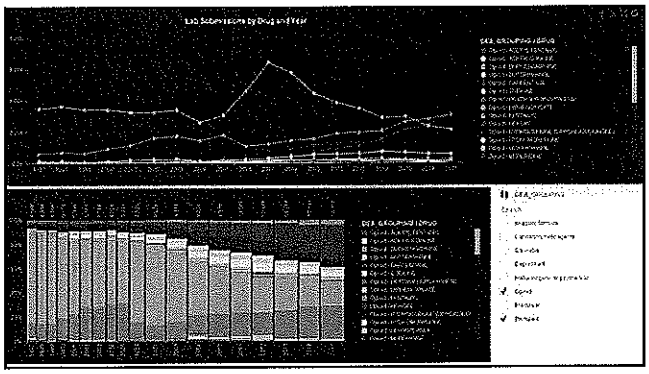
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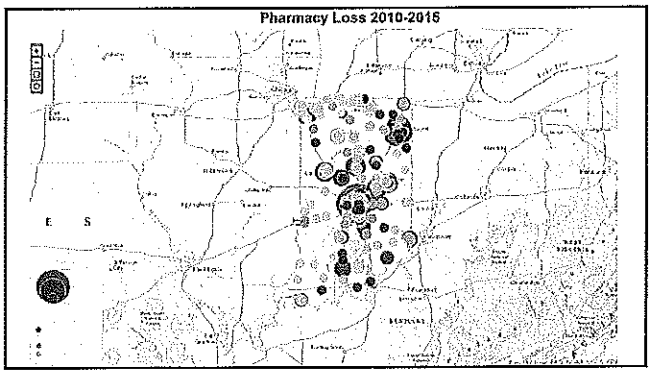
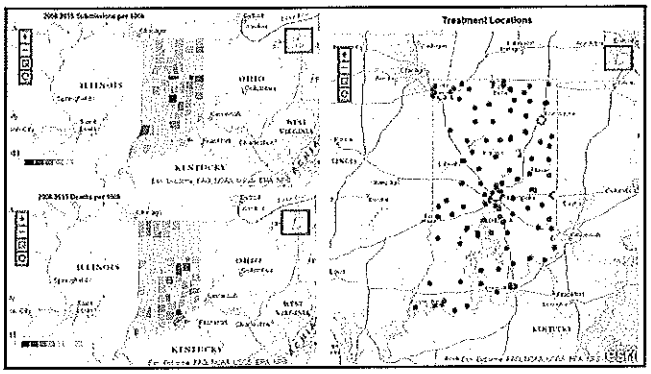
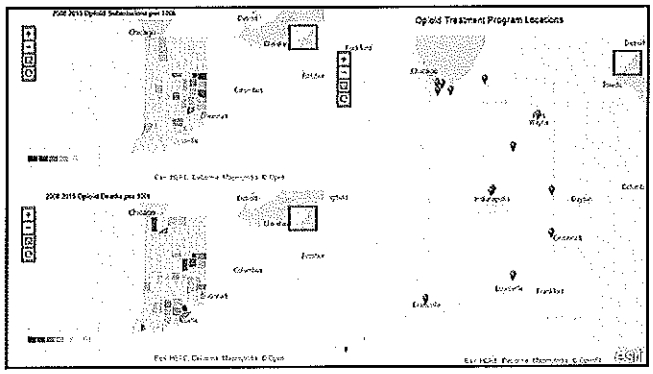

Pharmacy Loss 2010-2015





Contact Information

Dave Matusoff
dmatusiff@gov.in.gov

Josh Martin
jmartin@gov.in.gov

MANAGEMENT AND PERFORMANCEHUB
GOVERNMENT MOVING AT THE SPEED OF BUSINESS

* GOVERNOR'S *
TASK FORCE
on Drug Enforcement, Treatment & Prevention

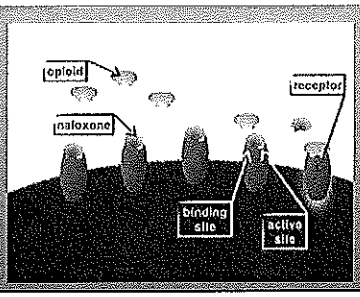
POLICE AND NALOXONE "THE INDIANAPOLIS EXPERIENCE"

Daniel O'Donnell, M.D.
Medical Director IEMS/IFD
Assistant Clinical Professor IUSOM Dept. of Emergency Medicine

WHAT ARE WE GOING TO COVER

- Describe the Indianapolis experience
  - How we started
  - What were the key steps along the way
- Present the science/evidence that has come out of this experience
  - Training
  - Patient outcomes
  - Give you necessary evidence to support your own programs
- Goal: Give you the information you need to development your own successful program

WHAT IS NALOXONE?

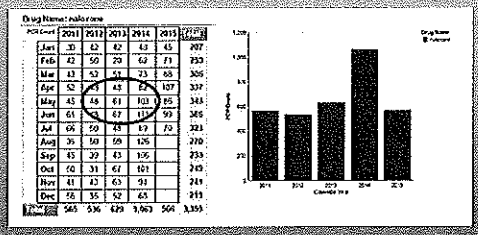


HOW DID THIS ALL BEGIN?

- IMPD Southwest District Spring 2013
- A "Motley Crew"
  - Police (all divisions)
  - EMS
  - Mental health/addiction centers
  - Schools
  - Criminal justice
- One Mission: How can we combat the rising crime that is associated with the opiate epidemic

CRIME

WE KNEW THIS WAS A PROBLEM



Drug Name: naloxone

MCI Count	2011	2012	2013	2014	2015	YTD
Jan	30	42	42	43	45	202
Feb	42	50	29	62	71	253
Mar	43	43	51	73	66	276
Apr	52	46	48	84	107	337
May	45	46	61	103	96	351
Jun	61	46	67	110	99	383
Jul	66	50	48	89	79	332
Aug	36	50	66	126		278
Sep	45	39	43	106		233
Oct	50	31	67	101		249
Nov	41	47	63	91		242
Dec	56	55	52	65		228
Total	565	536	629	1,063	568	3,361

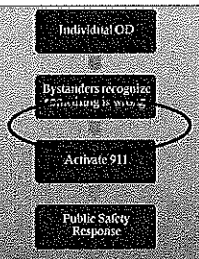
THINGS TOOK A TURN

- All parties realized that we "cannot arrest our way out of this problem"
- Had to take a fundamental approach
  - Education in the schools
    - Programs that go beyond current drug education/awareness
    - Not your average "Don't do drugs talk"
  - Look at ways to decrease the number of fatalities
    - Police naloxone?

BRIEF HISTORY OF POLICE AND NALOXONE

- Not necessarily a brand new concept
- A growing number of police agencies had been successfully delivering intranasal naloxone
  - Quincy, MA
  - Nassau County, NY
  - Boston, MA
- All had reported a fair amount of success

WHY WE THOUGHT IT WAS IMPORTANT

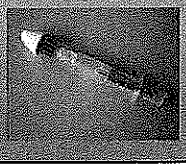


THE PROPOSAL WAS BORN

- We had the support within the district
- Had to go to the City County Building
- Emphasize the growing epidemic
- Stress the safety of officer delivered naloxone
- Highlight the new laws regarding naloxone
  - HB 227
- Devise a way to make it economically "feasible"
- After 20 minutes → All in for our pilot project

THE PROCEDURE

- All district officers trained:
  - Recognition of opioid OD
  - Administration of Naloxone intranasally
- If deemed an opioid overdose → 2mg Intranasal naloxone
- Brief report completed
- 100% patients transported
- If refusal → Immediate Detention
  - Concern for self harm



THE SW DISTRICT PILOT PROJECT

- Goal: Train 150 officers how to deliver a medication they may have only heard of
- Many were not "excited" about this opportunity
- Potential perceived barriers
  - Viewed as "enabling"
  - Goes beyond the scope of what a police officer was trained to do
  - Will they even be receptive to the training

THE TRAINING

- Had to be quick
- Stress the importance of the problem
- Answer the question "Why police"
  - Chain of survival
  - Time is lost in an overdose
- Dispel potential myths
  - Combativeness (< 3% documented)
  - Legal questions

ATTITUDES

- What would they think about the training program?
- Would they reject?
- Would it be effective?
- Is it even seen as a problem?

THE STUDY

- Performed a prospective investigation of officer attitudes towards naloxone training
- 117 subjects
- Asked to complete a standardized evaluation
  - Experience with opiate overdoses
  - Perceived difficulty of naloxone training
  - Perceived importance of naloxone training

WHAT DID WE FIND

Officer Responses to Survey Items Measuring Difficulty and Importance		
	Not difficult *N* (%)	Very difficult *N* (%)
How difficult was the training to administer nasal naloxone that you received today?	85 (72.6)	0 (0.0)
How difficult will it be to use nasal naloxone at the scene of an opioid overdose?	50 (42.7)	0 (0.0)
How difficult would it be to train police to use nasal naloxone?	39 (33.3)	1 (0.9)
	Very important *N* (%)	Not important *N* (%)
How important is it for police to be at the scene of an overdose to keep medical personnel safe?	84 (71.8)	0 (0.0)
How important is it for police to be at the scene of an overdose to enforce the law?	43 (36.8)	5 (4.3)
In your opinion, how important is it that other police officers be trained to use nasal naloxone?	51 (43.6)	8 (6.8)

Middle categories not shown

WHAT ELSE

- They were seeing it as well
  - 93.2% on an overdose in 1 year
    - 49.6% last month
- Training was not difficult
  - Officers should be trained
- Experience mattered
  - More overdose cases = higher competency

CONCLUSIONS

- Overwhelmingly positive attitudes towards naloxone training
- Consistent with literature showing that police are receptive to harm reduction interventions
- Prior experience with opioid overdoses increased confidence

THE BEGINNING

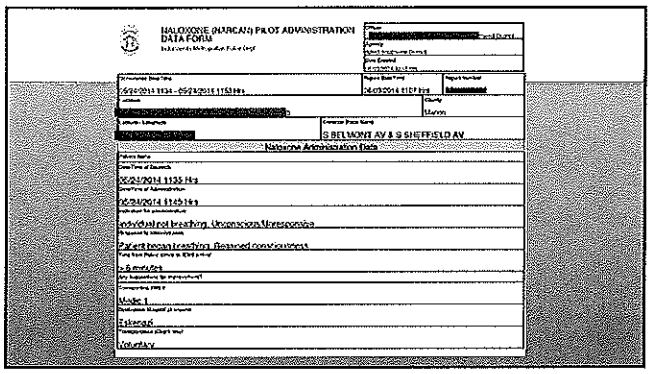
- Training was complete in 10 days
- Officers began using immediately
- Fire department asking about police naloxone
- "Racing to the scene"
- 100% feedback to the officers
- Time to go department wide

CONTINUATION

- Began training each district within IMPD
- Same model
  - Training
  - 100% medical director review
  - 100% feedback to officers
- Data collection

DATA COLLECTED

- Basic demographics
- Indications for administration
  - Breathing status
  - Level of consciousness
- Difficulty with administration
- Response to administration
- Need for Immediate Detention


NALOXONE (NARCAN) PILOT ADMINISTRATION DATA FORM

Naloxone Administration Data

S BELMONT AV & S SHEFFIELD AV

Individual not breathing, Unconscious/Unresponsive

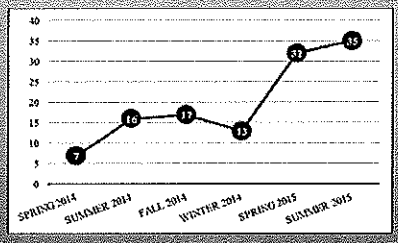
Patient began breathing, Regained consciousness

Voluntary

THE EVIDENCE

- Reviewed all police naloxone administrations from April 2014-August 2015
- Reviewed all required officer administration forms
- Examined EMS runs and hospital outcomes
- N = 121 officer administrations

ADMINISTRATION BY TIME OF YEAR



DEMOGRAPHICS

	Total Sample (N = 120)
Age	32.9 (8.94)
Sex	
Female	51 42.5
'Transported'	
Voluntarily Transported to Hospital	101 96.2
Involuntary Detention	4 3.8
Arrested	
Yes	22 18.3
No	98 81.7

INDICATORS AND RESPONSE

Overdose Indicators	N	%
Individual not breathing	39	32.5
Individual with slowed/abnormal breathing	67	55.8
Individual appeared blue	59	49.2
Individual unconscious/unresponsive	108	90.0
Response to Naloxone		
Began breathing	67	55.8
Regained consciousness	75	62.5
Vomiting	6	5.0
Became Combative	1	0.8
Nothing	22	18.3

Note: Indicators and responses are not mutually exclusive.

EMS AND HOSPITAL OUTCOMES

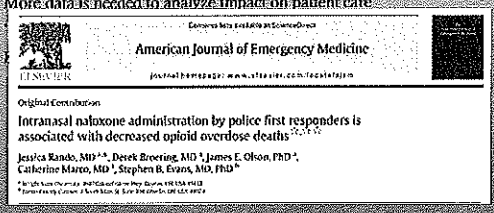
- Continuing to gather data
- Roughly 30% receive additional naloxone by EMS
- Almost 95% survive to the ED
- 90% ultimately discharged from the ED

WHAT DOES THIS MEAN?

- Police are appropriately recognizing opiate overdoses on the street
- Once recognized, police are safely and effectively administering naloxone
- Incidence of combativeness or need for scene escalation are rare
- Patients who receive naloxone from police have similar outcomes when compared to those who receive from EMS

WHERE DO WE GO FROM HERE?

- More data is needed to analyze impact on patient care
- [illegible]


Contents lists available at ScienceDirect

American Journal of Emergency Medicine

journal homepage: www.ajemjournal.com

Original Contribution

Intranasal naloxone administration by police first responders is associated with decreased opioid overdose deaths☆

Jessica Rando, MD[a,*], Derek Brewing, MD[a], James E. Olson, PhD[a], Catherine Marco, MD[b], Stephen B. Evans, MD, PhD[a]

WHERE WE NEED THIS NOW

- Rural communities
- EMS resources are spread out
- Includes ALS and BLS
  - Volunteer services
- Often times police are first on scene for an extended period of time
- As overdose time increases → increase potential for death
- This issue is not just an urban problem

WHAT DO YOU DO NOW?

- Multidisciplinary approach to combatting overdose deaths seams to be working
- Now that lives are being saved → Time to look into treatment
- "Outside the box" treatment?
  - Home naloxone prescriptions
  - Naloxone Rx from Emergency Dept
  - Alternative treatment opportunities

CONCLUSIONS

- This is one step
- Would not have been possible if not for support from a MULTIDISCIPLNARY team
- Officers are receptive to naloxone training
- Officers can be trained to correctly identify opiate overdoses and act
- Officer naloxone administration appears safe and effective

THANK YOU!

Questions?

* GOVERNOR'S *

TASK FORCE

on Drug Enforcement, Treatment & Prevention

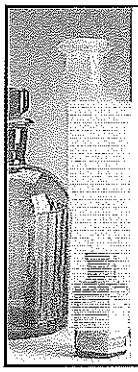
MARION GENERAL HOSPITAL MGH

Rural Hospital Taking Lead in Opioid & Heroin Abuse

Educational Efforts & Outcomes

Ann Vermillion, MBA, FACHE
Admin. Director Medical Staff Services & Community Outreach
Marion General Hospital
January 29, 2015

Governor's Task Force



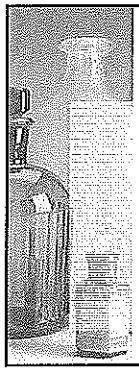
Jump to Conclusion: Estimated decrease in Rx Pills

MGH

> 64,900 pills in MGH ED

@ 34,000 pills in MGH Inpatient discharges & Physician Practices

@ 100,000 pills in one year



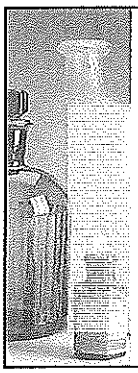
MGH: Mission for Change

STEP #1:
Evaluate the Opioid & Other Controlled Substance (OOCS) abuse:
Pull Measurable Data
– *MGH - Grant County - Indiana - USA*

STEP #2: Investigate
a. What can we do within our health system?
b. Who needs to be involved?

STEP #3: Implement OOCS Prescribing Guidelines

STEP #4: Educate - MGH employees, physicians & Community

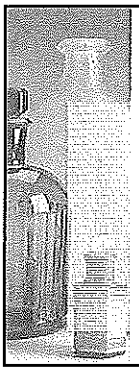


STEP #1

MGH

CSR Abuse: Affects at MGH

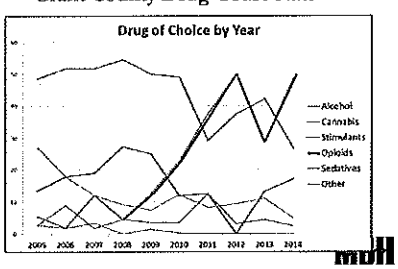
- Rise in patient requests in ED & Physician Offices
- Patient's disposition and aggressiveness
- Climate: threatening, volatile & disruptive = employee and physician dissatisfaction
- Q: Research how other hospital system's handling?
- A: NO MODEL, Create our own roadmap



CSR Abuse: Affects in our Community MGH

Reality Check
CSR were entering the streets of our community from Rx written from our medical staff.

STEP #1: A Local Epidemic
Grant County Drug Court Stats



Prior Community Tactics

Education and Awareness of
a. Locking up household Rx
b. Medication Disposal.

STEP #2:
Investigate
"What can we do within our health system?"

STEP #2: Self Evaluation

DETERMINE MEASURABLE DATA

- # units of OCCS were administered hospital wide
- # of doses of OCCS were administered in ED
- % of patients prescribed OCCS
- # pills prescribed in ED
- # average pills per patient in ED
- # of OCCS Rx written in the Primary Care/Specialty Offices

STEP #2: Self Evaluation

In 2012-2013
- -- 27,000 Doses (30,000 tablets) of hydrocodone containing pain reliever
- -- 10,000 Hydromorphone injections
- -- 7,000 Fentanyl injections
- – 11,000 Morphine injections

- Over 63,000 units of OCCS were administered hospital wide
- Over 9,600 doses of OCCS were administered in ED
- 2,343 (21%) patients prescribed OCCS
- 36,400 pills prescribed
- 15.5 – average pills per patient
- Largest single prescription – Lortab 5-500 #60 for rib fracture
- Second largest prescription -- Norco 5-325 #40 for toothache

MGH Prescribing Guidelines in the ED

- Not to take place of clinical judgment
- Provide UNIFORM guidance to emergency care providers
- Treat the pain until they could see the referring specialty (3 days vs. 45 days)
- Appropriate treatment of acute pain
- Appropriate treatment of chronic pain

ED Prescribing Guidelines (cont.)

- Attempt to obtain photo ID or patient photograph upon arrival
- Once triage complete ALL patients will receive a copy of "Pain Management in our Emergency Department"
- Use of INSPECT – 100% employed 80% non-employed
- Urine Drug Screen if indicated

MGH Outpatient CSR Rx Guidelines: First Do No Harm

The Indiana Healthcare Providers Guide to the Safe, Effective Management of Non-Terminal Pain Recommendations

MGH Journey towards Education

Education for area Physicians, MGH Staff & Community

July 2012	INSPECT – IN Board of Rx JEAN Team & Judge Spitzer
Sept 2013	Howard County Dep. Prosecutor "4 Doctors jailed for Opioid Prescribing Patterns"
Jan. 2014	INSPECT – IN Board of Rx for ED team
Feb. 2014	MGH Rx Guidelines Education • CME for all ED Staff & Physicians, all medical Practitioners and MGH staff • Service Line meetings (Medical & Surgical) • MGH Primary Care Physicians Meeting • MGH Board of Directors • Community Prevention and Education – 19 local organizations
Mar. 2014	5 sessions at MPD yearly officer training

Communication Timeline

- Community Roundtable – Feb. 25, 2014
  - Law Enforcement Agencies
  - Healthcare Providers
  - JEAN (Joint Effort Against Narcotics)Team
  - Grant Co. Courts and Prosecutor's Office
  - Local Pharmacies
  - Substance Abuse Treatment Providers
  - Social Services
  - Medical Providers
  - Grant County Health Department

Community Support a Priority

Our mission to provide a safer community is supported by:

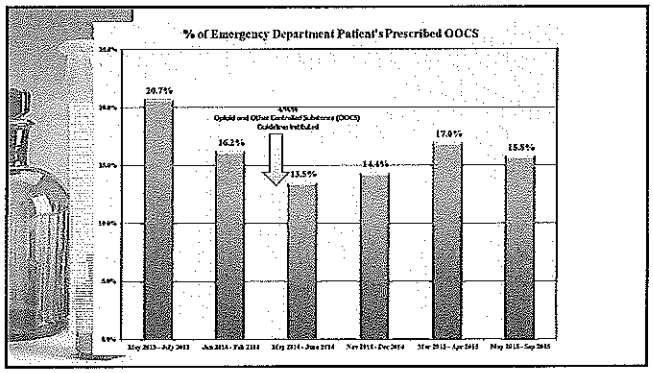
Walgreens CVS pharmacy Walmart pharmacy MARSH meijer pharmacy

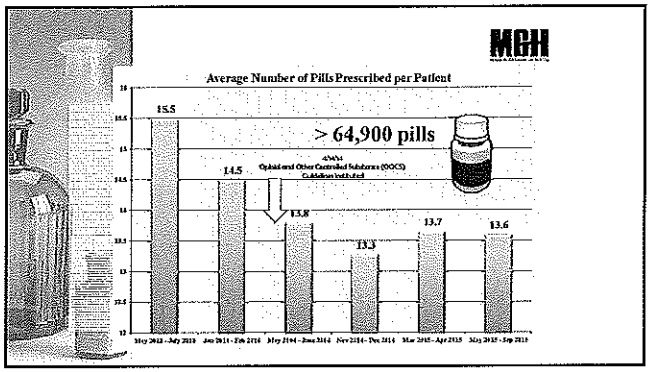
STEP #3

MGH OOCS (Opioid & Other Controlled Substances) Prescribing Guidelines Launched

APRIL 1, 2014

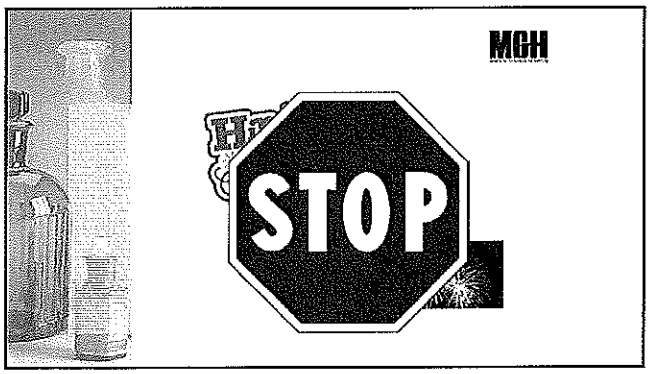
How are we doing in Grant County: 1 year later?
STEP #5: Evaluate and Awareness





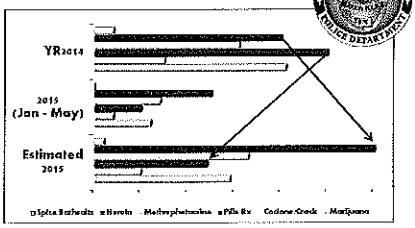
Estimated decrease in Pills

> 64,900 pills	in MGH ED
@ 34,000 pills	in MGH Inpatient DC & Physician Practices
@ 100,000 pills	in one year



Monitoring Addictive Behaviors in Grant Count: Changes in Drug of Choice

JEAN Team Drug Task Force Statistics



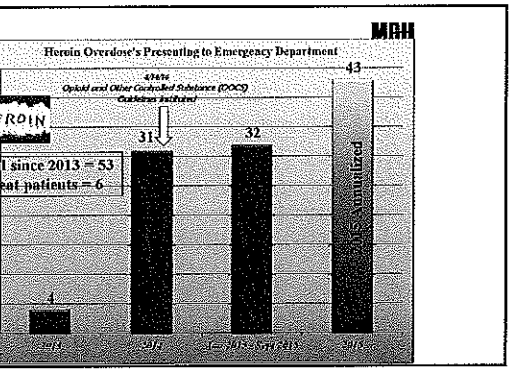
JEAN Team Drug Task Force Statistics

Type of Cases

	2015	2014	2013	2012	2011
Marijuana	37	41	34	31	24
Cocaine/Crack	8	15	17	16	21
Pills Rx	147	53	21	31	33
Methamphetamine	42	33	24	16	32
Heroin	102	140	8	6	5
Spice/Bathsalts	8	6	0	4	9

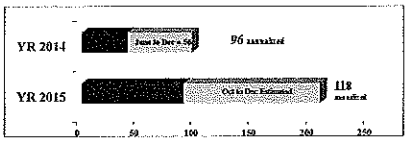
Type of Arrests

	2015	2014	2013	2012	2011
Marijuana	21	20	7	17	16
Cocaine/Crack	12	14	15	11	21
Pills Rx	9	16	11	5	13
Methamphetamine	20	10	11	10	8
Heroin	131	121	3	12	9
Spice/Bathsalts	4	3	11	0	0

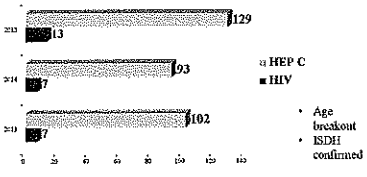


Narcan Use – Reversal Agent for Opioid Overdose

- EMS started administering intra-nasal Narcan June of 2014
  - EMS administered Narcan 56 times in 2014 (beginning in June) Average 8 per month
  - EMS 2015 Year-to-Date has administered Narcan 89 times (average 10 per month)



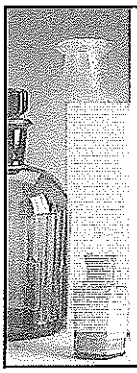
MGH Data



Notes:
- *MGH data: Preliminary users, labs we report to ISDH.*
- *Does not deduct transmission or contracted through intravenous drug use.*
- *May not be newly diagnosed, but new to our system.*

Continuous Education

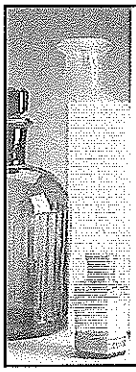
- Rise in Heroin – Community Task Force for Evaluation
  - -Held July/August
- CME offerings
  - - Presentation – 1 year later
  - - Climate of Heroin abuse



Heroin Task Force

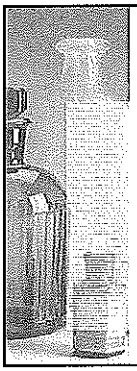
September 29, 2015
Broke into Committees:

1. Data Collection
2. Heroin & Substance Abuse Care Plan
3. Education, Outreach & Communication
3. Syringe Exchange Program (Logistics)



MGH Take-away

- No model or tool kit for our journey. We created our journey from scratch.
- Not an MGH problem, must engage community entities.
- Severely lacking in substance abuse treatment centers. (Cut off the abusers ≠ treatment)
- Journey never **STOPS.**



Thank you

Ann Vermillion, MBA, FACHE

Admin. Director Medical Staff Services
& Community Outreach
Marion General Hospital

Our MGH mission to provide a safer community is supported by:

Walgreens CVS pharmacy Walmart pharmacy MARSH meijer pharmacy

Grant County Prosecutor's Office
Grant County Coroner's Office
Grant County EMA
Grant County Department of Health
Grant County Dental Society
Community Alternatives
Family Service Society, Inc.
Department of Child Services
Indiana Health Center
Mental Health & Substance Abuse Bowman Hill Health Center

* GOVERNOR'S * TASK FORCE on Drug Enforcement, Treatment & Prevention

Working together to make Indianapolis the safest place to receive healthcare in the nation.

Indianapolis Coalition for Patient Safety

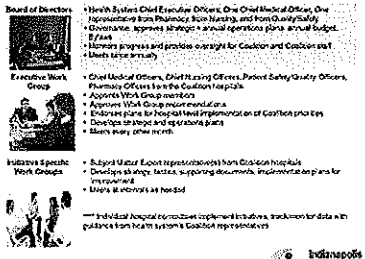
ICPS Members

Community Health Network
Franciscan St. Francis Health
ESKENAZI HEALTH
St. Vincent Health
Indiana University Health
Richard Roudebush VA Medical Center

We will *not compete* on safety and will share openly best practice

Indianapolis Coalition for Patient Safety

Indianapolis Coalition for Patient Safety, Inc. Table of Organization



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ED Prescribing workgroup

- Interdisciplinary team
  - –Emergency Dept. Leadership
  - –Providers
  - –Nurses
  - –Pharmacists
  - –Social Work
  - –Pain Management
  - –Behavioral Health
  - –Addiction Services

Indianapolis Coalition for Patient Safety

Current State

- Recognition that:
  - –ED's continue to be a source for many patients to obtain prescription narcotic pain medicine for a variety of chronic and acute conditions.
  - –Emergency practitioners are often challenged to find ways to manage these patients in order to:
    - •prevent undue harm
    - •address pain management in a sustainable fashion and discourage chronic pain management in the ED setting
    - •prevent opiate dependency in patients
    - •prevent nonmedical use of opiates in habituated patients who may or may not require narcotic pain medication to manage their medical condition.

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Process

- •Reviewed national programs
- •Reviewed current state at each member health-system with focus on existing practices and lessons learned
- •Developed future state

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Process

- Future state:
  - –Draft guidelines for appropriate ED narcotic prescriber practices including differentiation of acute vs chronic pain
  - –Suggested routing of follow-up and long term management
  - –Scripting to facilitate difficult conversations.
  - –Patient educational materials for consistent message across the community

Indianapolis Coalition for Patient Safety

Future State

- ED Narcotic Prescriber Practices
  - –Patient Assessment
  - –Differential Assessment (acute vs chronic)
  - –Possible indicators for chronic pain
  - –Exclusions
  - –Determine appropriate patient-specific treatment

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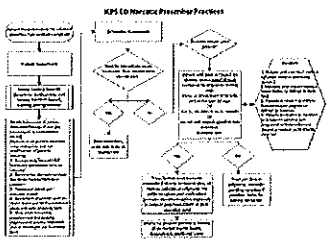
ED Narcotic Prescriber Practices



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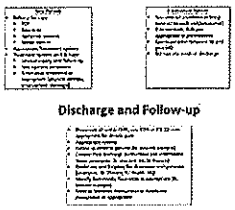
Chronic Pain Patient



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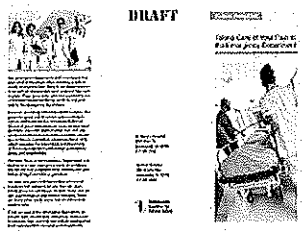
Patient Communication



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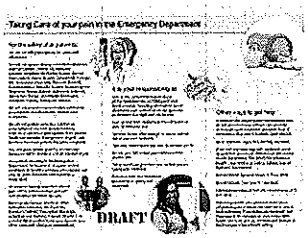
Patient Communication



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Patient Communication

- Taking Care of your Pain in the ED:
  - –Pain relief is important when someone is hurt or needs emergency care
  - –If you are in pain, pain management is one of the most important things we do during your visit to the emergency department
  - –Providing pain relief can be complex
  - –Misuse of pain medication can cause serious health problems and even death
  - –Referenced U.S. Controlled Substances Act of 1970
  - –Our main focus in the Emergency Department is to look for and treat emergency medical conditions
  - –We use our best judgment when treating pain and follow all legal and ethical guidelines
  - –We treat new pain with the smallest amount of medicine that will work for you.
  - –Narcotics pain medications are not always the best choice and are not used to treat all pain related problems
  - –If you are seen in the emergency department for chronic pain, we will work with you to make a plan to improve your care that may include staying away from medicine that can be abused or addictive

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Patient Communication

- For the safety of all patients
  - –We will not refill prescriptions for controlled substances.
  - –We will not replace missing controlled substances (included list)
  - –We will not provide new controlled substances prescriptions to patients with chronic pain complaints.
  - –We will not provide controlled substances prescriptions if you have already received controlled substances prescriptions from another health care provider, Emergency or Urgent Care facility in the recent past for the same complaint.
  - –Any new prescriptions given for a controlled substance will be limited to a small number of pills
  - –All patients seeking relief from chronic pain will be referred to their primary care physician for follow up care
  - –Before prescribing a narcotic or other controlled substance, we check the Indiana Scheduled Prescription Electronic Collection and Tracking Program (INSPECT) or a similar database that tracks your narcotic and other controlled substance prescriptions.

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Patient Communication

- It is your responsibility to:
  - –Give us the correct information about all the medicines you are taking and your medical history including information about an existing pain contract so we can give you treatment that is right and safe for you.
  - –Lock up your pain medicine so it is not stolen or used by someone else.
  - –See your doctor often enough so you do not run out of your pain medicine.
  - –Take your medicine the way your doctor tells you to.
  - –Do not give, sell or take pain medicine from anyone else.
  - –Tell all healthcare providers you see that you are taking pain medicine.
  - –Follow up with your healthcare provider or on-going pain treatment

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Patient Communication

- Other ways to get help: (customize per facility)
  - –Assistance with ongoing pain management may be obtained from your primary care provider or through a pain treatment specialist. A list of providers in your area is available upon request.
  - –Examples:
    - Go to xxxxxxxx.org to find the help you need.
    - If you feel you need help with substance abuse or addiction, please call XXXXXXXXX Behavioral Health Department, The XXXXXXXX Behavioral Health Crisis Hotline, or Central Indiana Area of Narcotics Anonymous:
    - XXXXXXXXXX Behavior Health 317-xxx-0000
    - XXXXXXXXXX Crisis Line 317-xxx-0000
    - Central Indiana Area of Narcotics Anonymous (317) 875-5459
  - –Following up with your personal physician or establishing one if you do not have one is vital to your well-being. These things are important and they need to be managed by your longer-term health care team and are not managed the best in the Emergency Department setting.

Indianapolis Coalition for Patient Safety

Contributors

Ehjay Amora, PharmD	Eskenazi Health
Bryan Bendelot, MD	Community Health Network
John Box, MD	Roudebush VAMC
Dee Bunney, MD	St Francis
Amber Cummins, PharmD	St Vincent
Nabiha Gill, MD	Roudebush VAMC
Heather Hall, MSW, LCSW	St Vincent
Kathy Hendershot, RN	IU Health
Kanaka Jonak, PharmD	Eskenazi Health
Tracy Martin, MSN, RN	Eskenazi Health
Brian Mosher, PharmD	IU Health
Charles Diamond, MD*	Eskenazi Health
Barry Moffatt	St Vincent
James Ryser	IU Health
Charles Shuffelbarger, MD	IU Health
Lisa A. Swanson, MBA, RN, CENP, CCRP*	IU Health
Dawn Sullivan Woytal, MSN, RN, ACNS-BC, CEN	Community Health Network
Ryan Vems, MD	St Vincent

Indianapolis Coalition for Patient Safety

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TASK FORCE

on Drug Enforcement, Treatment & Prevention